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Vol. CX SEPTEMBER, 1916 Number 9

NASHVILLE JOURNAL
OF
MEDICINE AND SURGERY

Established 1851

CHARLES S. BRIGGS, A. M., M. D., Editor and Proprietor
E. S. McKEE, M. D., Cincinnati, Associate Editor
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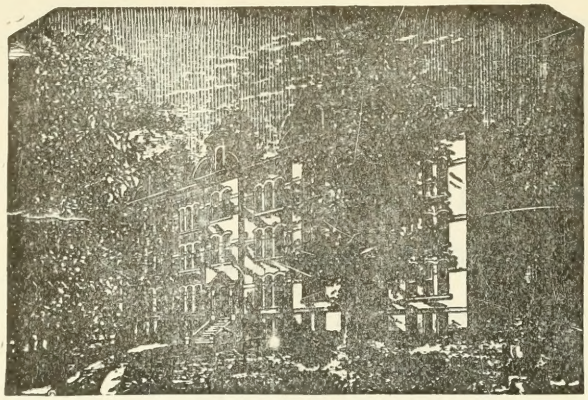

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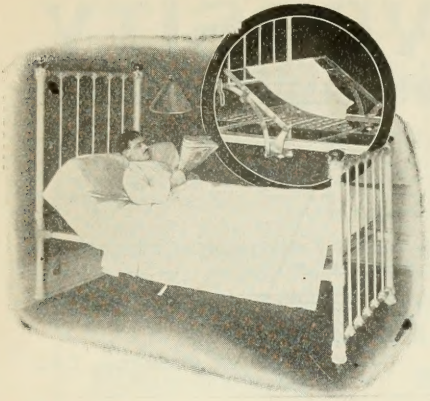

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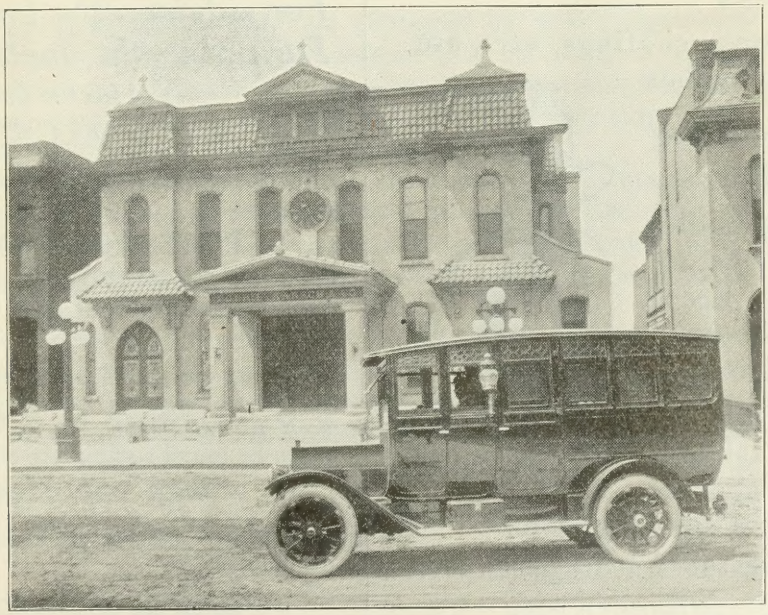

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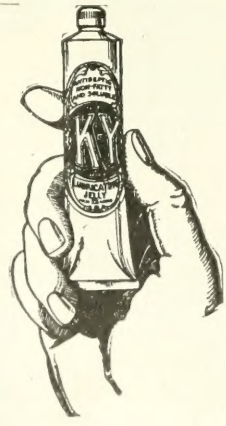

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NASHVILLE JOURNAL
— OF —
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A.M., M.D., Editor.
W. T. BRIGGS, B.A., M.D., Associate Editor.

VOL. CX. SEPTEMBER, 1916. No. 9

Original Communications

PSYCHOLOGICAL FACTS IN MEDICAL TESTIMONY.*

BY T. D. CROTHERS, M.D.,
Hartford, Conn.
President New York Medico-Legal Society.

It is the general opinion expressed by trial judges and lawyers in active practice that medical testimony is unsatisfactory. The physician, however learned he may be, does not appear well in a critical examination concerning facts of science and his own experience.

In sharply contested cases, where motives and interpretation of conduct are in question, and attempts are made to secure some exact statements, it is found that experts differ widely, always on particularly and often on general principles.

The press echoes the opinions of lawyers and judges that experts can be found anywhere to swear to any statement; either for or against the question at issue. Often the conclusion is reached that this testimony depends upon fees and other considerations. This is most unfortunate, and while

*Read at the May meeting of the New York Medico-Legal Society, St. Andrews Hotel, New York City.

it has some basis in the history of famous trials and in individual instances, is unjust and creates a false impression.

Questions of responsibility and insanity with distinguished experts on both sides often reach opposite conclusions and are certainly very confusing. Both judge and jury are inclined to disparage such testmony and in many instances judges have instructed the jury not to consider the statements of physicians.

The fault lies here, more in the system and the loose way in which the evidence of this kind is collected and presented. Lawyers demand a degree of positiveness in answer to certain questions and expect scientific conclusions, which are by no means real in other departments. The law itself furnishes the best example of conflicting decisions and uncertain applications of principles, and why they should insist on science presenting an unquestioned array of facts, to which there can be no exceptions, is anomalous.

No medical expert or man of scientific character can on the witness stand state more than general principles, and when these are applied to particular instances, there must always be confusion and doubt.

There is one thing overlooked, in the study of these disputed cases, and that is the psychology of the expert. By this is meant, his degree of training and competence to determine the meaning of certain facts which are in question. Generally the expert is a hospital superintendent or an assistant whose whole life has been spent in the study of the insane and who lives in an atmosphere far removed from the normal. The patients he sees are chronic cases whose conduct is so abnormal as to be beyond question. In this field he is undoubtedly most competent to determine the range of thought and conduct, and decide on the competency of the person.

Going outside into fields of active life, and studying healthy types in different circles of life brings new conditions and new circumstances in which he can be no more expert to determine than others.

In reality the expert's knowledge is limited to the grades of persons that he is constantly associated with and also to the questions of management and housing, rather than the causes which have produced their difficulty. The inmates of an asylum are standardized ,according to certain conceptions and supposed to follow a uniform progress without variation or change, hence the expert's judgment of people in other circles can not be compared with those whom he is familiar with.

If the questions at issue in the courtroom concern the pronounced abnormality of the prisoner, and these present symptoms, which are common to the expert's everyday observation, he is able to give very accurate judgment and make it very clear to others.

Such a witness called on to decide the disputed insanity of a business man who is probably on the border lines without very pronounced symptoms, of either sanity or insanity can not be positive or clear. He has never seen types of this class. He is not familiar with the surroundings or conditions that would lead up to this. A few years later, when the man became violently insane and comes under his observation, he can tabulate his symptoms and causes in a general way, with considerable accuracy, but go back to the beginning and determine which direction the defects will take, without being familiar with the surroundings and activities of the man, is practically impossible.

Often the hospital expert is a very close observer of symptoms of men under suspicion, and frequently he is not a reader of modern psychology and has little or no knowledge of the influence of mind over the body, and other influences which effect the mentality of the patient. Hence unless the patient is under his observation constantly, his judgment will vary widely.

The pronounced insane and the man or woman with feeble mentality of long duration are easily understood and when questioned concerning such persons the expert's answers are always clear. A second class of experts are us-

ually men who specialize in mental and nervous diseases; often connected with private hospitals as consultants and often have very large clientages. Such men, if they have been educated abroad, have a very strong bias for materialistic explanations and theories and particularly to label every sort possible phase of nervous disease. This has a very learned sound and often is a distinction with a difference and sometimes, it gives a very superficial view and confused ideal of real causes.

Many of these experts are teachers in colleges, authors of books and seem very scientific and profound in their descriptions of the disorders of the brain and nervous system. When they appear on the witness stand and are subjected to a very close scrutiny, their descriptions and explanations fail to impress one.

Not unfrequently these men are not readers of modern psychology, but have the most antique philosophies of mind and body which put them out of touch with many of the modern views of sanity and responsibility. Most of these men are very skillful in diagnosis, but their positions as teachers often make them dogmatic and assertive and narrow their real field vision which is painfully apparent in the courtroom.

When the text-books which they have written are produced by sharp lawyers who insist on their defending either their own opinions in books or in the cases in question, and ask for explanations of why they differ, there is considerable confusion. The witness is discomforted and his efforts to make clear, theories and teachings, only serve to increase the doubts and suspicions of his testimony. The witness has been accustomed to express himself to credulous students, and to an uncritical public in papers, and when these views are called in question he is not prepared to defend them in any satisfactory way. The impression he leaves is that of bias and uncertainty and the assertions that his testimony is paid for are accepted as the only explanation.

Of these two classes of specialists, the asylum superintendent makes a better impression on matters that he is

familiar with, and abnormal conditions that have come under his own observation in institutions. The nerve specialist does not appear so well, unless the conditions in question involve some nervous condition that he is more or less familiar with. Even then, his evidence is lacking in breadth, simply because he is not familiar with the conditions and surroundings, and mental atmosphere of the person in question.

There is a third specialist, who appears in courtrooms. He is the general practitioner, or the physician, or in active service as a surgeon or who follows some particular branch of practice. He is usually a highly respectable man who has had considerable service in police courts and has a taste for medico-legal questions. He is called as a witness to wills to decide the capacity of the testator and he is a general family adviser and often a teacher in colleges, and a leader in the circles in which he lives. He is usually able to make his views clear to the court and jury, but does not bear technical scrutiny and exhibits a want of knowledge when subjected to the questioning of the council. Oftentimes, he makes a very excellent witness, because he recognizes the limits of his knowledge and rarely assumes any technical questions, dependent on conditions of which he is not clear. In many of the important legal contests in this country, these three classes are in evidence. Each one seems to have a special personality of his own and curiously enough, there is a striking disagreement on general principles as well as on details.

Where these experts are prepared outside of the courtroom and the character of their testimony is determined and fixed, they may make a very good impression, but when the same class of experts appear on the other side and are actually taught to take an opposite view and support it by equally conclusive facts and evidence, there is great doubt and the impression that all this is a matter of consideration and purchase, is prominent in the minds of many persons.

Experts are no different from any other class of medical men, except they may have some special particular knowledge in certain directions. This may be faulty, or it may be

exact, but if it is along the line of their everyday work, it should deserve the highest place as a record of facts.

In disputed cases the attempts to draw dividing lines and boundaries concerning sanity and insanity, abilty to determine and power of the will involves so much that is unknown and impossible to ascertain, with any kind of accuracy, that there must be confusion and uncertainty. The ordinary physician will of course differ. There is great confusion in the law concerning the exact degrees of responsibility and irresponsibility, and curiously enough, judges differ as much as expert medical witnesses. One class of judges will insist on the letter of the law, regardless of the spirit and intent. Another will interpret the law according to their own conceptions of what it should be.

If the judge is a broad-minded, liberally educated man, with a good deal of common sense, he will probably approximate justice more positively than would others under the same circumstances.

A reaction is evidently taking place in the administration of justice for capital crimes. The attempts to make out insanity and with a limited responsibility is so involved and so uncertain, particularly where the facts are not clear, that of necessity, more or less confusion will follow. The settlement of wills opens a very important field for expert testimony and here the same difficulty obtrudes itself. If the witness is not familiar with the surroundings and circumstances of the man who made the will and the probable motives of his life, he will miss the central point which the law seeks to establish as controlling.

Another great error is permitting witnesses to be examined technically in open court on questions that can not be settled by off-hand decision. As a result of this confusional condition in courts by medical expert testimony very serious miscarriages of justice occur.

A study of criminals confined in prisons bring out these facts. Many persons here have been found guilty from foolish technical and confusing testimony. Their real condi-

tions were never recognized. On the other hand there are men at liberty who are persistent violators and disturbing agents of law and order, who should come under legal control, but for a variety of reasons are permitted to remain at large. If they come under legal recognition, farcical trials give them liberty again. Evidently the fact is becoming recognized in a great many ways the attempts to adjust the disturbed conditions and administer justice in criminal courts is medieval and sadly needs change.

Judges, lawyers, and courts follow prestiges and theories and decisions from the past, regardless of any change in the conditions of life and modern conceptions of living. Medical experts add to this and bring into prominence the weakness and inconsistency of leaving the most obstruse conditions of mental activity and responsibility to a jury, who are largely incompetent by training and habits, to reach any just conclusions. A trained judge is far better able to reach just conclusions than twelve ignorant men picked up anywhere in the neighborhood.

The State of New York has passed a law which is evidently a very great advance. It provides that the judge, with the approval of the council on both sides, may appoint three experts or more, according to the gravity of the case. These experts shall have full opportunity to examine the prisoner at all times and under all conditions, and finally render a decision in writing, which will be submitted to the judge and come under the scrutiny of the council. These experts are to defend their written statements and have opportunity to make this defense on paper in direct answers to questions. This testimony read to the jury is to be accepted as final. The advantages here are that the expert can have sufficient time to study the questions in the case and compare them in every way possible, to determine their exact meaning. Should the experts make two reports—a majority and minority one, they can have opportunity to compare their differences, but it must be done on paper and this must be subjected to the scrutiny of council and the court.

This would do away with the unhappy exhibits which the expert is forced to make in his attempts to answer the cross questions of the lawyer. Two cases already settled under this new law have been very satisfactory. In all probability this will be extended to include nearly all disputed cases where mental health and vigor are concerned.

Proceedings of Societies

AMERICAN PROCTOLOGICAL SOCIETY.

Eighteenth Annual Meeting, Held at Detroit, Mich., June 11 and 12, 1916.

"Why Proctology Has Been Made a Specialty"—By T. Chittenden Hill, M.D., of Boston, Mass.

In this address Dr. Hill calls particular attention to the inadequate treatment that rectal fistula receives at the hands of the general surgeon. He claims that the general surgeon "has never taken the pains to learn the underlying principles of a fistula operation, nor has he the requisite skill, experience or inclination to carry out the necessary steps in the postoperative treatment of these cases, to bring them to a successful conclusion."

While in London there are two hospitals devoted to the exclusive treatment of disease of the rectum, Hill feels that better results can be obtained by establishing special departments in our large general hospitals. He urges that proctologists be appointed to all general hospitals. The many advantages of staff association, consultations, etc., in which proctology touches on the work of men in other fields, would prove of mutual benefit.

He believes that in the near future a fifth year will be added to the present four-year medical course. This fifth year will probably be devoted to the medical specialties and proctology should be included among them. The undergraduate should have the chance to acquire reasonable proficiency in the newer methods of examination and treatment of rectal disease.

Dr. Hill also presents a formal paper for the consideration of the members of the society under the title of

"Prolapsus Ani in Adults"—By T. Chittenden Hill, M.D., of Boston, Mass.

The theory is advanced that all cases of procidentia recti are the results of neglect or improper treatment of what was in the beginning a simple form of mucous membrane prolapse. Correction of the condition early may prevent serious infirmity later in life.

He describes at length an operation modified after that of the late Mr. Goodsall, of London, Eng.

In this operation he employs a multiple suture. He advises removing the excess of tissue distal to the ligature.

The operation is performed under local anesthesia and is advised for patients of all ages. It is particularly suitable for use in prolapse of the age.

The author claims that the operation is painless, short, and easily performed. There is absence of hemorrhage and the end results are satisfactory.

"The Postoperative Treatment in Rectal Surgery"—B. W. H. Stauffer, M.D., of St. Louis, Mo.

This paper is based upon a review of over 25,000 rectal cases treated, of which 1,500 were operative . Four hundred of these cases had been operated upon previously by approved method by other surgeons.

There are two reasons for these 400 secondary operations. First: Not selecting the operation indicated by the pathology. Second: Improper postoperative attention.

In selecting an operation or treatment the following requirements must be met. First: Complete restoration of functions. Second: Time required for cure. Third: Pain produced.

Unsatisfactory results—complete or partial incontinence often are caused by needless traumatism. He does not believe in divulsion. Divulsion of nerves causes sensory disturbances.

Incontinence may be due to fistula operation. Believes that where the fistula opens more than two inches above the sphincter the two step operation is indicated.

In dealing with malignancy he mentions the operation of Evans as producing the least mutilation and disturbance of function in selected cases.

Operations should only be performed after a definite diagnosis has been made.

It is insisted that the best results are obtained by proper diagnosis, careful preparation, appropriate operation, and careful after-treatment. The surgeon should always make the first dressing and should always inspect the operative field daily. The patient should be kept under observation until recovery is assured.

"Photography for Record and Teaching" — By Collier F. Martin, M.D., of Philadelphia, Pa.

Martin draws attention to the fact that students may be better interested in a lecture if their attention be fastened by an appropriate picture or illustration. After experimenting with photographs or drawings, passed among his class, and also with charts hung on the wall, he found that he could better interest the students with lantern slides thrown upon a screen. The darkness of the room tends to lessen the distraction and to encourage concentration. By having photographs of actual cases, as well as of the different steps in an operation, it was easy to interest the class and to explain far better than could be done even in a clinical lecture.

The equipment is briefly described and suggestions are given as to proper rendering of color values by the use of lightfilters.

Attention is called to the necessity of proper exposure and lighting to give negatives with sufficient detail to properly show pathologic conditions. Such negatives only are useful for illustrations, record or lantern slides.

Many case histories are incomplete without a photograph to clarify the description.

Hints are given for copying, making line drawings, diagrams and classifications to produce lantern slides suitable for teaching.

It is suggested that every hospital have a department devoted to photography. This could easily be operated in conjunction with the X-ray department.

"Abstract—Some Important Pathological Conditions About the Rectal Outlet: Lantern Slide Demonstrations"—By

Granville S. Hanes, M.D., F.A.C.S., Louisville, Ky.

Tubercular ulcerations do not occur as frequently in the mucosa of the rectum and sigmoid as is generally believed. Amebic and various types of bacterial ulceration produce dysenteric symptoms that often lead to emaciation and exhaustion.

Active tubercular ulceration is always accompanied by a decided increase in the temperature and pulse rate. These are not characteristics in other types of ulceration. In tubercular ulceration there is a history of constant and progressive symptoms while in amebic there is usually a history of improvement and relapses. Tubercular ulceration involving the rectum and sigmoid seldom yield to treatment. Amebic ulceration in this climate can be cured by one method or another.

Bacterial types of ulceration are usually very difficult to treat. Within the last two years I have found cauterization with the high tension electric spark to be a most valuable means of treatment.

Tubercular abscesses often occur about the rectum when patients otherwise show no evidence of tuberculosis. The abscesses and subsequent fistulae are characteristic in that there is a great tendency to undermining of the skin. The external openings are, therefore, large with a livid appearance of the surrounding cutaneous structures. They point to impending trouble which may be precipitated months or years hence. This being true it is of great importance that

we direct the habits, hygiene, etc., of individuals thus afflicted.

Fistulae of long standing with one or more very small external openings with a history of an extensive abscess are very difficult to cure. From external evidences they appear to be very simple. Usually the finger when introduced well into the rectum will be able to detect by careful palpation the hard indurated sinuses which often extend surprisingly high up by the rectum.

Internal fistulous openings rarely, if ever, perforate the rectal wall unless there is some pathology primarily in the rectal mucosa whereby its resistance is impaired. The internal openings of the fistulæ are usually in the anal canal. The anal tissues are most always diseased before the abscess is formed, therefore, it is reasonable to suppose that the infection passes out through the diseased anal structures and is responsible for the abscess.

There are occasional fistulous tracts that extend up by the rectum to considerable heights and are very tortuous. It is difficult to follow these sinuses to their terminations when operating. When the wound heals and a small opening remains we may feel fairly certain that some part of the original fistula was not reached. It is then advisable to inject bismuth paste which will often effect a cure.

Pruritus ani is undoubtedly a local infection. The focus of the disease is below the pectinate line and at the anal margin. It has been my practice to remove the diseased tissues at the margin of the anus and from the emulsion of these diseased structures bacteria are cultivated and an autogenous vaccine administered to the patient. The operation with autogenous vaccine obtained in this manner give decidedly the best results.

"Abstract of Paper—Preliminary Report: Anatomical and Bacteriological Findings of the Anorectal Region
Dr. J. Rawson Pennington, Chicago, Ill.

This preliminary report is submitted in lieu of my paper on "Indications for Making a Rectal Examination."

Today the question of "focal infection" is uppermost in the minds of the medical profession. Much consideration has been given to practically every point in the body from which focal infection may emanate except that of the anorectal region.

Experimental investigations show that not only crypts of Morgagni, but what appears to be diverticuli are found also in this region. The Medical Research Laboratory of Chicago, to whom specimens were submitted for examination, reports that these diverticuli are lined with stratified squamous epithelium. Also that streptococci, straphylococci, colon bacilli, and other bacteria were found in their tunics and sacs.

We have observed that local and constitutional diseases may be produced by injecting the various bacteria obtained from these diverticuli into animals.

I am investigating the value of these diverticuli as points of focal infection and their role as causative factors in hemorrhoids, fistula, constipation, arthritis, endocarditis, and other acute, and chronic, and local and constitutional infections.

"Some Observations on Hernia In Relation To Intestinal Stasis"—By William M. Beach, M.D., of Pittsburg, Pa.

After reviewing the theories of Keith relative to nodal zones situated at different levels in the intestinal musculature the author says that:

1. We have tried to define intestinal stasis to be a physiologic-anatomic disturbance of peristalsis by an inhibiting influence through nodal zones of the myenterium, located in the œsophago-gastric junction, the duodeno-jejunal area, ileocecal region and in the rectum. This demonstrated in the laboratory must be certified clinically.

2. Anatomic distortions, as kinks, adhesions, ptoses, etc., lead to stasis by distributing the ganglia controlling peristalsis.

3. Hernia is a frequent manifestation of visceral displacement concomitant with stasis.

4. Long truss wearing with great pressure tends to rectal disease.

"Abstract—Intestinal Symptoms Due to Achylia Gastrica"
—By Alois B. Graham, A.M., M. D., F.A.C.S., Clinical Professor of Proctology, Indiana University School of Medicine, Indianapolis, Indiana.

In 5,758 patients presenting gastro-intestinal symptoms, and in every one of whom repeated gastric analyses were made, a diagnosis of achylia gastrica was made in 378. This is about 6.5 per cent, or a ratio of 1 to 5; 100 were males and 278 were females. The youngest was 17 years, the oldest 73 years. 60 per cent were between the ages of 40 and 60 years. In 90 per cent the subjective symptoms were chiefly intestinal in character. The bowels were reported regular in 38; constipated in 112; loose (diarrhea) in 142; irregular in 86. Diarrhea was the most frequent symptom and was present in 37.5 per cent of the cases. Description of three groups of cases. Description of the stools which were at times quite characteristic. Rectal symptoms rarely reported. Internal hemorrhoids found in every case. Rectal examination of no value, except that of exclusion, in determining the cause of the intestinal symptoms. In cases where constipation was chief symptom, there was not anything of special interest.

There was no return of the gastric secretion in any of the cases. The course of achylia gastrica is a protracted one. Under proper therapy the prognosis, as to fairly good health, is excellent.

Diet alone in the severe cases of diarrhœa was not successful. Astringents and intestinal irrigations were unsuccessful. Hydrochloric acid and pepsin in sufficient dosage is rational therapy and the only one which gave anything like satisfactory results. In some cases diet and hydrochloric acid failed. In these cases a nervous element was

present as the administration of bromides in suitable dosage produced most excellent results.

Patients are comfortable as long as they continue treatment. If discontinued even for a brief period, there is a recurrence of the diarrhea. These patients should be correctly informed as to the prognosis; namely, that as long as there is evidence of an absence of the gastric secretion, just so long must they adhere to a rigid diet and take hydrochloric acid and pepsin.

"Observation on Fissure in Ano"—Rollin H. Barnes, M.D., Editor of The Proctologist and Gastroenterologist., St. Louis, Missouri.

The author considers fissure as an ulcer and believes that traumatic causes are not true etiological factors in the production of this trouble but that it is necessary that the tissues become inflamed and hence friable and easily torn in order that fissure be formed. He believes that catarrhal inflammatory conditions are frequently the result of an excessive carbohydrate diet and sometimes an excessive fat diet.

In the treatment of fissure he recommends palliative treatment by correcting the diet with reference to the excess of carbohydrates and fats and placing the patient on a proteid diet for a time. When operation is necessary he believes that the object should be drainage rather than paralyzing the muscular fibers. He also advocates the use of a small enema before defecation in order to avoid irritation from the stool. It is very important to keep the wound clean by hot sitz baths and the hot enema, in order that any foreign substance may not remain in the wound.

"Abstract—Malignant Transformation of Benign Growths." By Frank C. Yeomans, A.B., M.D., F.A.C.S., Adjunct Professor of Proctology, N. Y. Polyclinic Medical School and Hospital, New York City.

The benign tumors of the colon and rectum considered were of the polypoid type—solitary polyp—multiple adeno-

mata and villous tumor. All originate from the intestinal mucosa, are of the same histologic structure but differ in number, size, form and the relative amounts of glandular and fibrous tissue present.

The writer cites the theories of origin of multiple adenomata as advanced by Meyer, Liebert and Schwab and G. Hauser and H. C. Ross's views on the formation of benign growths. Yeomans thinks these tumors inflammatory in character and notes the frequent history of colitis or dysentery in these cases, intestinal parasites as causal in others and the positive evidence of the role of irritation as furnished by therapy, colonic lavage, or colostomy and irrigation benefitting some patients and curing others. He reports a case of multiple adenomata in a man, aged 30, colostomized in 1913, with marked benefit. Many tumors have disappeared, the remainder have retrogressed and the patient is working regularly. There is no evidence of malignant change.

That benign growth become malignant is beyond cavil but its cause involves the same enigma as the cause of cancer itself. The writer cites the work of neoplasms of Waldeyer, Adami, Cathcart, and others, as well as modern research on the transplantation of tumors and the parasitic theory of their origin. He concludes: "All that can be stated positively is that cancer begins as a small local process; that it excites no reaction in the blood whereby a diagnosis can be made; that the individual cancer cell is the parasite of cancer, and whatever eventually explains the origin of cancer will also explain the transformation of a benign into a malignant growth."

Yeomans reports the transformation of a simple adenoma into an adenocarcinoma in a man, aged 76, who had rectal bleeding of 8 years duration, progressive constipation and a tumor that in recent years could not be reduced within the rectum. The tumor, 3½x2 inches, was attached just within the anal verge. It was removed under local anesthesia and both clinically and histologically was adenocarcinoma.

Villous tumor or adenoma tends to recur in malignant form so should be extirpated early, thoroughly, and radically.

Multiple adenomata are the most important and serious type of benign growth of the intestines. Their usual site is the lower colon and rectum. Clinically they are malignant from diarrhea, hemorrhage, etc., and if neglected over 40 per cent become actually malignant. Improper local treatment, as snaring, curettage, and cauterization is followed by malignant recurrence in a large proportion of cases.

The curative, operative procedure indicated is enterotomy, either in the colon above the growths, or in the terminal ileum when the entire colon is affected. If the tumors disappear, the enterotomy may be closed. If they persist, after prolonged irrigation and the patient's general condition warrants it, partial or total colectomy is indicated with implantation of the ileum low down into the sigmoid, the operation being performed either in one or preferably in two stages.

"The Treatment of Hemorrhoids by a New Method"—By E. H. Terrell, M.D., Richmond, Va.

The author presents a simple, safe, and efficient method of curing selected cases of hemorrhoids by the injection of quinine and urea solution. During the past two years 127 patients have been treated by this method with only one recognized failure. Injection of quinine and urea in solutions of from 5 to 20 per cent strength produces starvation and atrophy of the hemorrhoids. The series includes only uncomplicated internal hemorrhoids. The results of the treatment of 127 patients justify conclusion that the method is simple, safe, and effective in properly selected cases.—*Abstract.*

"Abstract on the Etiology of Vaccine Treatment of Pruritus Ani." Louis J. Hirschman, Detroit, Mich.

Hirschman presented a preliminary report of his work on the bacteriology of pruritus ani as based on the original work of Murray at Syracuse. The work of H. C. Ward, bacteriologist, in conjunction with Hirschman's work shows that the streptococcus fæcalis was present in the twenty-five cases, but the vaccine treatment in these cases, especially that of the autogenous vaccines, has resulted in improvement or systematic cure in but four cases, while the treatment of the surgical lesions present, or by dietary, or hygienic measures, has resulted in relief or cure of all the remaining cases.

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Abstract of Paper Entitled, "Further Observation on Pruritus Ani, Its Etiology and Treatment." (A sixth report based on results of original research.)

Dr. Dwight H. Murray, of Syracuse, N. Y., read the sixth annual report of his original research work on pruritus ani and vulvæ adding reports of 25 cases to the former series of cases, making 123, the bacteriology of which shows 95 per cent of the cases a streptococcic infection as the etiology for these troublesome conditions. He stated that his claim, that the streptococcus fecalis is the etiology of pruritus ani, is now confirmed by many leading physicians throughout the United States, who have been investigating the subject.

He finds from the experience of this past year that far better results are obtained by the use of autogenous vaccines with more than 1,000 million dead germs to I c. c.

He states that not one of the cases of pruritus ani and vulvae pruritus scroti in the 123 cases have had diabetes and, as a result of this, he questions very strongly whether diabetes is ever the cause of these conditions, unless as a complication, and under such condition there would be a general pruritic condition of the skin.

Last year, in his fifth report, he described cases of pruritus ani that did not show improvement under the administration of the autogenous, streptococcic vaccine. These cases were later found to have a staphylococcic infection as a complication and when an autogenous staphylococcus vaccine was administered with the autogenous, streptococcic vaccine improvement resulted. He has found proof of this same condition during the past year and believes that these cases show a characteristic whitish appearance of the skin in spots, particularly around deep skin fissures.

He also found further proof of one of the conclusions, in a former paper, i. e., where there is a rectal pathology with pruritus ani, plus a skin infection, that an operation for relief of these conditions will cure the rectal pathology, but will not cure the pruritus ani. If the streptococcic skin infection does not exist the operation will be very sure to cure pruritus ani.

During the six years that Dr. Murray has been doing this work he has never had as prompt and satisfactory results from treatment as during the past year. In his report of the present condition of patients treated during the past five years, he shows that practically all of the patients have retained a part of the benefit originally received and a large majority of them consider themselves cured. Time will give the proof of this.

While some of the cases still have a little itching from time to time, they state that it is very easily controlled, by simple methods.

Dr. Murray is more firmly convinced than ever that operactions for the cure of pruritus ani, such as Ball's operation and modification of it, are absolutely contraindicated and should never be performed.

"Ano-Rectal Injuries."—Samuel Goodwin Gant, M.D., L.L.D.

The author stated that while the rectum is protected by the buttocks, and bony structures, it is frequently injured

by external trauma, expulsion of hardened feces, and foreign bodies, swallowed or introduced through the anus, such wounds being contused, lacerated, incised, or perforated.

Laceration of one or all of the rectal coats, results from careless examinations, introduction of imperfect syringe nozzles, bougies, proctoscopes, or other instruments.

Perforating wounds are caused by bullets, knife thrusts, and pointed objects that have been swallowed, or introduced into the rectum, except when due to specific ulcers or cancer.

Recently many pneumatic rectal ruptures, the result of compressed air introduced through the anus, in a spirit of fun, have been reported.

The injection of carbolic acid into hemorrhoids is responsible for extensive ano-rectal injuries.

Symptoms—The chief manifectations of superficial ano-rectal injuries are, bleeding, sphincteralgia, frequent micturition, and painful defecation; symptoms that are exaggerated, when wounds are extensive.

Infected wounds are characterized by a chill, temperature, throbbing pain, swelling, and a thick yellow discharge.

In extensive injuries of the upper rectum, hemorrhage is profuse. There is shock, the patient collapses, and soon exhibits symptoms of peritonitis, when the peritoneum is involved.

Diagnosis—The diagnosis of ano-rectal injuries is easy, when the nature of the accident has been learned, the degree of hemorrhage, bruising and swelling have been noted, and the buttocks, anus, and rectum have been inspected, and digitally and proctoscopically examined.

Treatment—Minor injuries take care of themselves, while extensive injuries may require simple or complicated treatment.

Incised wounds are sutured, under aseptic conditions.

Contused, lacerated and pneumatic injuries are drained at one or more points, following irrigation, and the removal of ragged edges and necrotic tissue. Subsequently they are treated by drainage and topical applications, as fistula wounds.

Injuries of the bladder and urethra are immediately closed by sutures when feasible, but if not, the bladder is drained, and the wounds here and in the rectum are permitted to heal by granulation.

Small recto-vesical rents are sutured, but where the rectum or sigmoid is extensively injured, the bowel is resected, or an artificial anus is established.

Recto-vaginal tears are repaired by suturing the vaginal before the rectal side of the wound is closed.

"The Consideration of Rectal and Colonic Disease in Life Insurance Examinations."—By Alfred J. Zoebel, M.D., Fellow of the American College of Surgeons; Chief of Department of Rectal Surgery, San Francisco Polyclinic and Postgraduate School, San Francisco, Cal.

All important data concerning the vital organs is obtained by a medical life insurance examiner by direct examination and by precise methods. On the other hand life insurance companies evidently do not attach much importance to the condition of the rectum and colon—not to mention the rest of the alimentary canal—for they seem willing to assume that these organs are free from disease solely from the favorable answers given by the applicant to routine printed questions asked by the examiner. That this is a fallacy, inasmuch as it paves the way to the acceptance of poor risks, and occasionally to the rejection of a good one, is shown in this paper.

Applicants almost invariably deny having or ever having rectal or colonic disease. The writer thinks that perhaps the main reason for this general denial is the ease with which these affections can be concealed from the examiner, unless he makes an examination.

The average individual knows little about his ano-rectal region, and unless there is severe pain or itching, alarming bleeding, or annoying dysentery, he thinks it of little importance and unworthy the attention of either himself or

the examiner. The rectal surgeon often sees individuals who look and feel in the best of health (outside of "a little attack of piles") yet who are found victims of well advanced malignant disease of the rectum or colon. Unless a rectal examination be made such a person could easily pass a life insurance examination.

The examiner should look out for those little fistulous tracts which cause no pain and discharge but little secretion, as they are frequently the primary manifestations of tuberculosis, and may appear in those who are otherwise apparently healthy. A severe stricture of the rectum may be present in a man outwardly perfectly healthy and insurable. If no history of his condition was volunteered such a person could pass an examination unless the rectum was examined.

If a history of hemorrhoids is secured, or if on examination, it should not be forgotten that although their existence does not consitute a good cause for rejection, they often accompany liver, spinal cord, genitourinary and uterine disease.

In cases where a suspicious anemia is found to be due solely to bleeding from hemorrhoids, these individuals could be conserved to the life insurance business if put in the way of regaining their health so as to become insurable.

If a rectal examination is made the condition of the genito-urinary organs in the male can be investigated at the same time, while in the female accurate information can be obtained about their pelvic organs without subjecting them to a vaginal examination. At the present time insurance companies do not demand an examination of the female generative organs but accept their answers to the questions whether they ever had any uterine disorder, and if pregnancy now exists.

In conclusion, the suggestion is offered that medical examiners should lay more stress upon the questions regarding the condition of the bowel and rectum. They should enquire carefully whether there is or has ever been a sanguineous, purulent or mucous discharge from the rectum. A history

of chronic constipation or of diarrhea should be considered worthy of further investigation. A rectal examination, both digital and instrumental, should follow if there is need therefor, or whether there is the slightest suspicion that by it something may be revealed.

That medical examiner is the most "efficient" who not only secures his company from poor risks but also saves it business which otherwise would be lost. The utilization of rectal examination helps attain "efficiency."

"Spasmodic Stricture of the Rectum."—By Louis J. Krouse, M.D., F.A.C.S., Cincinnati, Ohio.

Dr. Krouse says that spasmodic stricture of the rectum was often called phantom stricture on account of its imaginary existence.

He makes the statement that in the early part of the last century it was more frequently diagnosed than later on. At the present time, the opinion regarding the existence of such an affection is equally divided between those who are firm believers and those that doubt its existence.

After quoting the statements of various authors well versed in rectal pathology, he expressed his own opinion in its existence and reports several cases. He also makes the statement and agrees with a few writers who believe that spasmodic stricture is often the forerunner of the more serious disease of benign stricture of the rectum. He reports several cases.

He claims that spasmodic stricture is not a disease but only a symptom of some other disease located in the rectum or in an adjoining organ.

His conclusions are:

First—That it is not a common affection.

Second—That it is easily detected on digital examination.

Third—That it often terminates in an annular fibrous stricture.

Fourth—That it involves the lower Houston valve.

Fifth—That a rectal ulcer is the most important etiological factor.

Sixth—Curing the ulcer in its early stage lessens the chances of the development of an annular fibrous stricture.

Syphilis regarded as a contagious disease as other exanthemata is characterized by its chronicity and virulency. The only exception to its point of inoculation being confined to tissues covered by squamous epithelium, is within the rectum.

Its frequency in the rectum and anus is not realized and, in consequence is not recognized by the profession. Its relationship to fistulæ and stricture is emphasized, and the importance of tuberculosis in these two conditions minimized. The successful treatment of fistulæ is proverbial. The possibility of stricture, resulting from secondaries later in life, suggested.

Abstract—"Acute Angulation and Flexure of the Sigmoid a Causative Factor in Epilepsy. Report of Nine New Cases with Four Recoveries." By W. H. Axtell, M.D., A.M., Bellingham, Wash.

Review—In December, 1910, I published my first list of thirty-one cases—eight private and twenty-three asylum cases; in August, 1911, a further report on ten private cases with three recoveries. This included three additional asylum and two private cases, making in all thirty-six cases. The three reported cured have remained so for a period now of over four years. One additional case (No. 4) of the original list of ten private cases has had no return of the convulsions since ceasing treating two years ago; treatment seemed at the time to increase the irritation as reported.

Additional Cases—Since last report I have had nine additional cases with four of them remaining free from seizures for from one year to two and a half years, making in all forty-five cases reported with eight recoveries to date.

Observations—From my observations I am convinced that those who acquire epilepsy after the fifteenth year are more amenable to successful treatment than when commencing earlier in life. In my judgment surgery can give but little relief except where there is a definite history of inflammatory adhesions holding the angulations and flexures—in fact the condition of fecal stasis precludes surgery of the colon until the condition is first relieved, which when so relieved a prime factor in the production of the trouble is eliminated. A new and undescribed cause of the intestional ptosis which is so generally present in these cases is the separation of the recti muscles, which are so essential to a thorough evacuation of the colon and for the support of the abdominal organs.

The essential failure of treatment of these conditions lies in the fact that so few recognize the true condition, and, if the condition is recognized, there is not sufficient persistence in relieving the condition, or an ignorance as to the amount of material the colon holds and as to when it is well empted, that is the reason so many fail and as a result mutilating surgery is resorted to without getting results commensurate to the gravity of the surgery resorted to—the first intimation of the true condition is found upon opening the abdomen—then details are carried out which should have been used in the first instance, then surgery would be unnecessary.

"The Relation of the Roentgenologist to the Proctologist."—By Walter I. LeFevre, M.D., Cleveland, Ohio.

This paper calls attention to the advancement made in roentgenology in recent years, and gives statistics as to the men devoting their entire time to the subject. He also mentions the increase of special literature upon the subject, as well as the immense manufacturing interests which have sprung up.

The conclusion is drawn that to the proctologist the X-ray is of value just in proportion as he is interested above the sigmoid flexure. Below this point the proctoscope gives direct information.

Because of the expense and the refinements of technic the writer feels that the proctologist should work in conjunction with his friend the roentgenologist.

"Position for Sigmoidoscopic Work."—By Donly C. Hawley, A.B., M.D., Burlington, Vermont.

A majority of writers express a preference for the knee-chest position, while a minority prefer some other e. g. Hanes, Sims, or the exaggerated lithotomy position.

Before the days of the pneumatic sigmoidoscope the position was of necessity such as would admit of inflation by atmospheric pressure. Here the knee-chest position was undoubtedly the most satisfactory.

The knee-chest position is trying and disagreeable for the patient and not easy nor always convenient for the operator.

Its use is frequently attended with embarrassment and fear on the part of the patient.

With the pneumatic tube the older method may be done away with.

Place patient in left lateral prone position with left arm drawn out behind back, the patient lying well over on deft chest and stomach, the knees flexed, the right more than the left and placed above and well over and beyond the left on the table and with the back concaved as much as possible.

In this position the abdominal muscles are relaxed, while in the knee-chest position they are apt to be contracted.

In a majority of cases the instrument may be passed easily and quickly over the brim of the pelvis and into the sigmoid colon as far as required or to its full length.

This method not advocated exclusively, but a more thorough trial is urged.

"Tuberculosis Cutis Ani."—By D. C. McKenney, M.D., F.A. C.S., Buffalo, N. Y.

An interesting case of tuberculosis of the anal skin is reported.

From the clinical study of the case Dr. McKenney infers that the infection started from the anal canal rather than in the skin around the anal orifice. An active respiratory infection, associated with aphonia, seems strong evidence that the infection was carried in the feces to the anus. Two photographs of the local condition were presented.

"A Brief Report of Two Cases of Anal Herpes Zoster."—By Lewis H. Adler, Jr., Philadelphia, Pa.

Dr. Lewis H. Adler, Jr., stated that cutaneous legions about the anal region are by no means unusual, and that the frequency of their occurrence is much less than one might reasonably expect from the function of the part; its more or less constant contact with germ-laden feces; the frequent congestion to which it is subjected and the attrition of the nates and adjacent structures induced by walking, etc.

That in this connection a very unusual condition, so far as his experience went, was anal herpes zoster, of which he had only seen two cases in his practice, both being in young women, one of whom thought she had contracted some venereal trouble from using towels in a public bathing establishment.

That in both instances, the eruption was preceded for several days by a mild febrile disturbance, with burning pains in the anal region; at times the sensations were neuralgic in character. That in both patients the lesions were confined to a definite area, affecting only one side of the anal cutaneous surface; that the eruption in neither case was very extensive nor numerous and there was no history of previous attacks or of similar trouble elsewhere.

That the vesicles in both cases followed the usual course of hespes zoster occurring elsewhere—the liquid they con-

tained was clear, translucent serum, at first; which gradusually became cloudy and later puriform. That they never evinced any tendency to rupture and in the course of ten days or two weeks, they gradually dried to thin yellowish or brownish crusts, which shortly dropped off—after which there was left a reddish spot, covered with the epidermis; and that these spots were very slow in disappearing.

That the local discomfort in both cases was not lessened on the appearance of the eruption, but more or less burning was experienced, until the eruption had practically disappeared and that in one case it continued for several weeks afterward.

That the pain was so severe, in one case, that family physician found it necessary, on several occasions to prescribe an anodyne.

That the treatment in each case was similar—internally —liquor potassii arsenate, six drops was prescribed, locally, the parts were cleansed with a two per cent creoline solution and freely dusted over with borated talcum powder. Over this a wad of absorbent cotton was applied and kept in place by an appropriate bandage.

"Abstract."—By Dr. William H. Kiger, Los Angeles, Cal.

Dr. Kiger reports six cases of pruritus ani treated by the vaccine method as suggested by Murray. Cultures were taken from the skin at the anal junction. In every instance, streptococcus haemolyticus found. No local application of any kind was used. The results are attributed to vaccine treatment alone. He discredits the use of stock vaccines, and suggests the use of autogenous vaccine only. Considers the focal infection as a prime factor in an etiologic way. Also he reports three cases evidently due to an infection from abscesses at the roots of teeth. He says that all of the cases reported had pyorrhea, and suggests a thorough examination of the teeth, together with an X-ray picture of the jaw. He believes that a reinfection often takes place.

Extracts from Home and Foreign Journals

SURGICAL

Distinction Between Boils and Abscesses.

The Supreme Court of Oklahoma, in reversing a judgment obtained by Plaintiff Mason, holds that a special accident and health insurance policy, providing for the payment of indemnity in the event the insured under certain conditions suffers from boils, is clear and explicit, and does not cover disability occasioned by a disease designated as "ischiorectal abscess"; and the courts have not the right to enlarge on the plain provisions of such a policy. The court says that the plaintiff, so insured, alleged that he suffered from deep-seated" boils. There was evidence offered by him that he was suffering with a disease designated as "ischiorectal abscess," and that this expression was synonymous with "boils." The trial court, however, found that there is a distinction between a boil and an abscess; that the term "ischiorectal" merely determines the locality of the abscess; that an abscess is a condition wherein the internal portions of the anatomy are affected, as an abscess of the liver or of the brain, but that a boil is external in involving only the skin; that by a preponderance of the testimony it was shown that there is a good reason why insurance companies should include boils and exclude abscesses in a health indemnity policy, the reason being that boils rarely prostrate or disable the patient, while abscesses usually do; that the one is included and the other excluded as a matter of economy. Yet, after making these special findings of fact, the trial court proceeded to render judgment in favor of the plaintiff on the ground that an insurance policy should be construed liberally in favor of the insured, and, inasmuch as the plaintiff paid the premium in good faith and thought he was pro-

tected by the policy, he should not be bound by technicalities. Was the question presented a technical one? The supreme court thinks not. The language of the policy was clear and explicit. It insured against boils, not against abscesses. If the findings was correct that abscesses are internal, while boils are external afflictions, involving only the skin, and this court is bound by that finding, the policy conveyed a clear and explicit meaning, which involved no ambiguity or absurdity. It insured against boils, and the courts have not the right to enlarge on the plain provisions of the policy and insure against abscesses.—*Journal of the Amer. Med. Asso.*

The Treatment of Hemorrhoids by Interstitial Injection.

T. Bird writes of this method of treatment of hemorrhoids, not because it is new, but because he thinks it does not receive the attention it deserves. It was used in this country by Hoyt some thirty years ago, and consists of equal parts of hazeline and distilled water, to which is added 10 per cent. of pure carbolic acid; the whole of the acid is not dissolved unless warmed. The bottle must be shaken, when the solution becomes turbid, and it is then ready for use. As much as 15 minims may be given at one sitting, though it is customary to begin with 3 minims. It usually requires eight or nine injections, at intervals of two days, to effect a cure. When this method is used, recurrences are very rare. Some cases in old people are better treated in this way than by cautery or incision.—*Medical Record.*

Early Ether Analgesia.

D. P. D. Wilkie recommends a method of producing ether analgesia for minor operations for which a local anesthesia is unsuitable and where the aparatus for administering nitrous oxide and ethyl chloride are not available. His method of producing brief analgesia is, after having made all prep-

arations for the operation, to place a Shimmelbusch mask over the patient's face and to pour 3 drachms of ether over the mask and bring a folded towel over the face and mask and keep it closely applied. It will be found that in from thirty to fifty seconds, provided the patient breathes deeply and regularly, the stage of analgesia has set in and will last from fifty seconds to three minutes, the usual duration being slightly less than two minutes. The writer finds this method suitable for such minor operations as incision and scraping of multiple abscesses of the neck, removal of septic ingrowing toe-nails, circumcision, cutting of projecting portions of two phalanges with bone forceps, etc. The patient is usually able to walk out of the operating room and feels no unpleasant after effects.—*Medical Record.*

MEDICAL

Death Following the Sting by a Wasp.

Recently death occurred to an engine room artificer of Portsmouth, England, who had been stung by a wasp while sleeping on board his ship. The swelling of his neck was so great that he had to be sent to the Haslar Hospital, where he died on the following day. At the inquest Surgeon Caldwell Smith ascribed death to bacterial infection caused by the wasp's sting. The deceased was a healthy man, hence the virulence of the infection must have been extreme. A verdict of accidental death was rendered.—*The Med. Times.*

Erysipelas Treated with Diphtheria Serum.

About two years ago Pollak recommended ordinary diphtheria antitoxin in the treatment of erysipelas and one year later Koller, a Swiss, briefly reported a case of his own in which he following successfully the plan of Pollak. In the

Correspondez Blatt fur Schweizer Aertze for July 8, Koller reports his second case. The patient was an old woman who was subject to attacks of facial erysipelas which had hitherto yielded to ichthyol applications. In the present attack ichthyol had been of no avail. After nearly all of the face and scalp had become involved, and the patient presented a high morning temperature, 3000 units of diphtheria antitoxin were injected. A remarkable decrease in swelling was very soon apparent and subjectively the patient was much better. By the end of twenty-four hours the swelling seemed to have disappeared, but an area of tenderness remained in the scalp, 1000 more units of antitoxin were given. She was now objectively well, although probably by reason of her age her general condition was somewhat grave, she being extremely weak, with insomnia and night sweats. At the end of five days she was discharged cured.

In comparing his two cases Koller finds several points of parallelism which show that the serum acts directly upon the cause of the disease. These refer to the sudden arrest and regression of the local process and a critical deferescence accompanied by profuse sweating. The second patient seemed doomed. Taken by themselves these two cases prove nothing, but taken in conjunction with Pollak's results they tend to corroborate the latter. The author apparently uses colloidal silver in the routine treatment of erysipelas and used it perfunctorily in the reported cases, but had never seen any constant improvement follow its use when given alone. It is possible, however, that the combination of serum and silver is superior to serum alone, and he would use both in severe cases or in the presence of special indications. He has seen cases in which a surprising improvement followed at once upon an intravenous injection of silver.

Koller's contribution is of great interest at the present time, because ichthyol has practically disappeared from the market as a result of the war. The price of the very small reserve is prohibitive for the treatment of a malady like erysipelas, the importer's price being quoted at $16 a pound,

and with the profit of the distributor and dispenser added the consumer might have to pay as much as 2 or 3 cents a grain. In hospital practice the normally high price of the drug has made it necessary to use cheaper applications when practicable, and in consequence it has never been possible to determine to what extent ichthyol is really a life-saving remedy. But deprived of it altogether public and private patients alike should be expected to suffer somewhat, and the serum treatment might to a certain extent offset the loss. *Medical Record.*

The Treatment of Tonsillitis.

A. T. Cuzner (Med. World) says that during ten years past it has been his custom to treat tonsillitis with local application to the tonsil of an exceedingly fine powder composed of benzoate of soda and sulphur.

To administer internally a cathartic of calomel and podophyllin, to be followed by saline cathartics.

As a corrective of the poisons generated by this disease, calcium sulphide, gr. 1-6, six to eight granules to be given each day for at least three days.

This plan of treatment has answered in such cases as have reached him for treatment.

Had his cases reached the point of suppuration of the tonsil, we would most assuredly have resorted to surgery for relief of our patients, for he holds that all collections of pus should be evacuated at the earliest practical moment.

But where the local inflamation has not reached this point the calcium sulphide and cathartics will usually prevent the same.

Many of the diseases of the North, when they take up their abode in our southland, seem of a less virulent nature, so it follows, as a matter of course, treatment has to be modified. At the North, Doctor Cuzner used to cauterize tonsils. Since residing in the South his treatment of many diseases

common to both sections has been modified.—*Practical Medicine*

OBSTETRICAL

Abdominal Pregnancy, Probably Primary.

McCann records the case of a woman, aged thirty-five, tertipara, who had an abdominal pregnancy that went to term. The waters were said to have come away. There had been very slight labor pains. She complained of a pain in the epigastrium. There was a hard mass in the left side which suggested the fetal head. No movements of a fetus could be felt, although she stated that she felt movements distinctly up till the preceding day. On vaginal examination the os was only enough dilated to admit the tip of one finger. No presenting part could be felt and there was no external hemorrhage, her chief complaint being epigastric pain, vomiting, and sleeplessness. Finally, about two teaspoonfuls of blood passed per vaginam. No decidua had been expelled. The abdomen was much distended and there was considerable venous engorgement visible in the abdominal walls. The abdomen was extremely tender on palpation, especially on the left side over the position of the fetal head and at other points where the fetus was palpable. It was however, difficult to make a detailed examination of the abdomen because of the extreme tenderness as well as the intestinal distention. The outline of the uterus could not be defined. The breasts were somewhat atrophied and in appearance were not suggestive of pregnancy, and no fluid could be expressed from either nipple. On vaginal examination well marked venous distention and blue discoloration were noted. The cervix was much softened and drawn upward, and the os uteri readily admitted the finger. No presenting part could be felt on vaginal examination.

An offensive purulent discharge issued from the vagina and the general condition of the patient suggested the pres-

ence of a severe toxemia. A free median incision was made, and as soon as the peritoneum at the upper part of the incision was opened a small quantity of black clot presented. On enlarging the incision the umbilical cord of a dark slate color, bulged into the wound. The hand was introduced and a rapid exploration made. The fetus was grasped by the legs and withdrawn without difficulty. The uterus was found to be enlarged to about the size of a five months' pregnancy, with a well-developed placenta, to which the umbilical cord was attached, firmly inserted in its posterior surface slightly in the right side. A strong odor of ammonia was perceptible during the operation suggestive of the presence of urine in the peritoneal cavity, although the amount of intraperitoneal fluid was inconsiderable. The intestines were carefully packed off with sponges and a rapid supravaginal hysterectomy performed, leaving the appendages in situ. The placental attachment seemed to fade away gradually on the lower part of the uterus, leaving the floor of Douglas' pouch covered only by the remains of the amniotic sac. Further remnants of the amniotic sac, brownish black in color, were found on the posterior abdominal wall, the uterovesical pouch, the descending and pelvic colons, the transverse colon and omentum, the ascending colon, and the peritoneum lining the abdominal wall. Although the fetus was dead, yet there were no adhesions of intestine or omentum to prevent its rapid and easy extraction.

The fetus of a female weighing 7 pounds had reduced full development within the abdominal cavity of the mother. It measured 14 inches from the vertex to the coccyx. The trunk and limbs were perfectly developed, but the head was enlarged, suggesting early hydrocephalus. The umbilical cord, 15 inches in length, was normally developed and was attached to a large well-formed placenta. The main placental mass was perched like a cap on the upper and back part of the uterus, while it spread laterally outward and still more downward so as to hide completely the uterine surface.—*The Journal of the Amer. Med. Asso.*

Method of Minimizing Pain of Labor.

The method used by Kostmayer is as follows: As soon as the pain of the first stage becomes definitely annoying, chloral is given in 10-grain dose and repeated in forty-five to sixty minutes, as indicated, as much as three doses being given, if necessary. When the character of the pain changes to the "bearing down" of the second stage, 1-8 grain of morphin is given as soon as this pain is severe enough to warrant it. It is rarely necessary to repeat the morphin, though this may safely be done after an hour or two. If labor is retarded in the least, or if in the judgment of the physician labor might safely be hastened, pituitary extract is given in graduated doses. As the presenting part begins to dilate the vaginal orifice, ether is given by the open-drop method at the beginning of each pain, and continued until the pain subsides.—*The Journal of the Amer. Med. Asso.*

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

THE GENERAL PRACTITIONER.

In this day of specializing in medicine and surgery one must often ponder over the future fate of the family doctor, the general practitioner. Will he be with us fifty years hence or will his good work simply be a matter of history, or will his shoes be filled by one especially trained in the art of referring cases to the right specialist? Such in fact is almost the duty of the family physician today in the larger cities. He can treat a toeache or mild bellyache but so soon as the case begins to look a little serious, the specialist is called and the family physician steps down and out, or if the family is wealthy and can well afford two doctors, he is retained in the case as a matter of courtesy. Even then there is often a kind of tacit understanding that his fee must be in inverse ratio to that of the specialist. If such a state of affairs exists today what may we not expect in fifty years! But perhaps in fifty years, the layman will be so highly educated in medical matters by newspapers and magazine articles that he can diagnose his ills and head for the right specialist that very first time. But woe be unto him if he makes a mistake in diagnosis, for it must be confessed that even at the present day when specialism is in its infancy the average specialist is extremely narrow, and most ills that flesh

is heir to are ascribed by each and every specialist to his special organ. If specialism is narrow today imagine how much narrower it might be in fifty years!

The question is, can we do without the general practitioner, and even though this were possible in the cities, what about the small rural communities where there are not enough doctors to divide the specialties among them even though each were specialists in several branches at the same time.

Figure any way you wish and yet you find the answer just as hard. The family physician is going, he no longer occuies his once exalted position, but can you imagine him gone, his name a memory and his unselfish work his only monument? Indeed specialism itself is a monument which hordes of family physicians, working in the past, have slowly erected. But like the germ which succumbs to poisons it has elaborated, the general practitioner, in his hard work, in his search for the truth, has built in specialism a monument which would crush him. It would crush him if it could, but it can not. The general practitioner will remain with us and all glory that has been his in the past will be doubled in the future. The specialist too is here to stay, but in the future the specialist will be a better general practitioner than he is today. How will this happen when yearly, monthly, even daily each specialty is becoming more and more intricate? We do not know but we think it will happen through great changes in the curricula of our medical schools, in a better selection of teachers, in a more thorough foundation in first principles and much less attention to isolated facts. Anatomy and morbid anatomy, physiology and pathological physiology, normal physical diagnosis, and the signs and symptoms of disease will be so thoroughly taught by competent teachers that when the student graduates he will be eminently qualified to get the most out of his hospital work and practice. And in return make himself more trusted and more invaluable. Hospital interneships are invaluable today and we would have many poor physi-

cians if all had to go into practice without some hospital training but, such training is partly wasted when the interne knows little anatomy, less pathology and much less physiology. So we must look to the specialists in these branches to teach the student so that when he leaves the medical school he will be qualified to do general practice or take up a special branch. In either case the foundation is laid and the edifice he erects will depend on his own labors. Today the foundation is the weakest part of the medical edifice but the medical curricula already show changes which promise much in the future and which will perhaps give us general practitioners such as have existed in the past and such as exist today in spite of the shortcomings of the old fashioned medical school.

Do You Know That

The hand that carries food to the mouth can also carry disease germs?

Health first is the highest form of safety first?

Tuberculosis and poverty go hand and hand?

The U. S. Public Health Service will send a booklet on flies and disease, gratis to all applicants?

The breast fed baby has the best chance?

Physical fitness is preparedness against disease?

Pneumonia is a communicable disease?

Cockroaches may carry disease?

One million two hundred thousand Americans die each year, it is estimated?

Heart disease, pneumonia, and tuberculosis cause more than thirty per cent of deaths?

Sickness lowers earning capacity?

The U. S. Public Health Service is the nation's first line of defense against disease?

Disease is the nation's greatest burden?

Sunlight and sanitation, not silks and satins, make better babies?

Low wages favor high disease rates?
A female fly lays an average of 120 eggs at a time?

DO YOU

Believe in national preparedness and then fail to keep yourself physically fit?
Wash your face carefully and then use a common roller towel?
Go to the drug store to buy a toothbrush and then handle the entire stock to see if the bristles are right?
Swat the fly and then maintain a pile of garbage in the back yard?

It is a remarkable fact, confirmed by many observations, that many physicans who have devoted considerable labor to the study of a particular disease have themselves died of that disease. One of the most interesting examples is that of John Daniel Major, born August 16, 1634, in Breslau, a physician and naturalist of no mean ability. Bitten early by the wanderlust, he studied at Wittenburg, took courses at many of the schools in Germany, and finally went to Italy, where he received the degree of doctor of medicine at Padua in 1660. Returning to his own country, he resided for a short time in Silesia, and in 1661 married at Wittenburg, Margaret Dorothy, a daughter of the celebrated Sennert. The following year his young wife was stricken with a plague and died after an illness of eight days. Distracted by his loss, Major wandered up and down Europe studying plague wherever he found it in the hope that he might discover a cure for the disease which had bereaved him. Spain, Germany, France, and Russia were visited by him. He settled in 1665 in Kiel, where he was made professor of botany and the director of the botanical gardens. He made frequent voyages, however, always in quest of the remedy for plague. Finally, in 1693, he was called to Stockholm to treat the queen of Charles the Eleventh, then ill with the plague. But

before he could render her any service, he contracted the disease and died on the third of August.

The bubonic plague of today is identical with the black death of the Middle Ages. Primarily a disease of rodents caused by a short dumbbell shaped microscopic vegetable, the pest bacillus, it occurs in man in three forms; then pneumonic, which has a death rate of almost 100 per ment; the septicæmic, which is nearly as fatal, and the bubonic in which, even with the most modern methods of treatment, the mortality is about 50 per cent. It is a disease of commerce, spreading around the globe in the body of the ship-borne rat. It is estimated that every case of human plague costs the municipality in which it occurs at least $7,500. This does not take into account the enormous loss due to disastrous quarantines and the commercial paralysis which the fear of the disease so frequently produces.

The disease is now treated by a serum discovered through the genius of Yersin. This is used in much the same way as is diphtheria antitoxin.

Plague is transferred from the sick rodent to the well man by fleas. The sick rat has enormous numbers of plague bacilli in its blood. The blood is taken by the flea which, leaving the sick rat, seeks refuge and sustenance on the body of a human being to whom it transfers the infection.

Since plague is a disease of rodents, and since it is carried from sick rodents to well men by rodent fleas, safety from the disease lies in the exclusion of rodents, not only exclusion from the habitation of man but also from the ports and cities of the world. Those who dwell in rat-proof surroundings take no plague. Not only should man dwell in rat-proof surroundings, but he should also live in rat-free surroundings. The day is past when the rodent served a useful purpose as the unpaid city scavenger. Rats will not come where there is no food for them. Municipal cleanliness may be regarded as a partial insurance against plague. The prayer that no plague come nigh our dwelling is best answered, however, by rat-proofing the habitations of man.

Modern sanitary science has evolved a simple and efficient weapon against the pestilence which walketh in darkness and striketh at noonday, and the U. S. Public Health Service has put this knowledge into practical operation and thus speedily eradicated plague wherever it has appeared in the United States.

Congress has recently made an appropriation for thirty-three additional assistant surgeons in the United States Public Health Service. These officers are commissioned by the President, and confirmed by the Senate. The tenure of office is permanent, and successful candidates will immediately receive their commissions.

After four years' service, assistant surgeons are entitled to examination for promotion to the grade of passed assistant surgeon. Passed assistant surgeons after twelve years' service are entitled to examination for promotion to the grade of surgeon.

Assistant surgeons receive $2,000, passed assistant surgeons $2,400, surgeons $3,000, senior surgeons $3,500, and assistant surgeon-generals $4,000 a year. When quarters are not provided, commutation at the rate of $30, $40, and $50 a month, according to the grade, is allowed.

All grades receive longevity pay, 10 per cent in addition to the regular salary for every five years up to 40 per cent after twenty years' service.

Examinations will be held every month or so in various cities, for the convenience of candidates taking the examination. Further information will be furnished by addressing the Surgeon-General, United States Public Health Service, Washington, D. C.

Clean Hands.

Disease germs lead a hand to mouth existence. If the human race would learn to keep the unwashed hand away from the mouth many human diseases would be greatly di-

minished. We handle infectious matter more or less constantly and we continually carry the hands to the mouth. If the hand has recently been in contact with infectious matter the germs of disease may in this way be introduced into the body. Many persons wet their fingers with saliva before counting money, turning the pages of a book, or performing similar acts. In this case the process is reversed, the infection being carried to the object handled, there to await carried to the mouth of some other careless person. In view of these facts the U. S. Public Health Service has formulated the following simple rules of personal hygiene and recommends their adoption by every person in the United States.

Wash the Hands Immediately

Before eating,
Before handling, preparing or serving food,
After using the toilet,
After attending the sick, and
After handling anything dirty.

Obituary

JOHN BENJAMIN MURPHY, M.Sc., M.D.,LL.D.

Dr. John B. Murphy, of Chicago, professor of the principles and practice of surgery in Northwestern University, died suddenly, from heart disease, at his summer home on Mackinac Island, Mich., on August 11th. Dr. Murphy had been in poor health as a result of overwork during the winter, but was not thought to be dangerously ill; his condition was considered to be partly the result of his having been poisoned at the banquet given to Archbishop Mundelein at the University Club, Chicago, last winter.

Dr. Murphy was born in Appleton, Wis., on December 21, 1857, and was educated in the public grammar and high schools, afterward entering Rush Medical College, Chicago,

from which he was graduated in 1879. After three years of general practice he went to Germany for study, and on his return he entered the field of clinical surgery in which he achieved great distinction, and to which he had contributed largely. In 1902 he was awarded the Laetre medal by Notre Dame University, a medal given each year to a Catholic layman who has done conspicuous service to humanity, science, art, or religion, and his work was recognized also by the University of Illinois which bestowed the degree of LL.D. on him in 1905, by the Catholic University of America, which gave him the same degree in 1915, and by the University of Sheffield, England, which in 1908 honored him with the degree of M.Sc. In addition to his work in the Northwestern University Medical School, Dr. Murphy was professor of clinical surgery in the Chicago Postgraduate Medical School, advisory surgeon of the Cook County Hospital and the Alexian Brothers' Hospital, chief surgeon at Mercy Hospital, and attending surgeon at the West Side Hospital. He was a member of the American Medical Association, of which he was president in 1911, the Illinois State Medical Society, the Cook County Medical Society, the American Association of Obstetricians and Gynecologists, the American Surgical Association, the Southern Surgical and Gynecological Association, the Western Surgical Association, the Chicago Orthopedic Society, the Chicago Surgical Society, the American College of Surgeons, and the Mississippi Valley Medical Association, an honorary member of the Royal College of Surgeons of England, and a life member of the Deutsche Gesellschaft fur Chirurgie, and of the Societe de Chirurgie of Paris.

Dr. Murphy, besides being gifted with an exceptional technical skill, was a man of striking originality, and he enriched medicine with many useful inventions; two of the most noted of these were the well-known "button" for intestinal anastomosis, and artificial pneumothorax, by the injection of nitrogen into the pleural cavity, for the compression and "splinting" of the tuberculous lung.—*Medical Record.*

Publisher's Department

"Pepsin" is undoubtedly one of the most valuable digestive agents of our materia medica, provided a good article is used. *Robinson's Lime Juice and Pepsin* (see advertisement in this issue) we can recommend as possessing merit of high order.

The fact that the manufacturers of this palatable preparation use the purest and best pepsin, and that every lot made by them is carefully tested before offering for sale, is a guarantee to the physician that he will certainly obtain the good results he expects from pepsin.

Straining at Stool.

It is pretty safe to say that any bodily condition that is aggravated by pressure or congestion is aggravated by that daily straining at stool which is the rule rather than the exception with such a large percentage of humans.

When one stops to realize that in the act of defecation, every abdominal muscle is brought into play, and that many individuals customarily strain at stool with a force great enough to cause their faces to flush and their temporal veins to bulge out, then it is that one appreciates the tremendous force brought to bear locally upon the abdominal and perineal muscles and generally, upon the whole body.

Since defecation is a necessary function, and can not be suspended, it would seem that the best remedy for the difficulty of defecation would be to supply the lubrication that is often lacking.

Whatever will supply such lubrication without enervation or untoward after-effect would seem to be the most desirable method.

There is one outstanding reason why "Interol" does away with, or at the very least minimizes, straining at stool, name-

ly, "Interol" has a peculiar *lubricating body* by which it mixes with the feces before they are feces, spreads over and mixes with them and lubricates them in their passage through the colon, until they reach the rectum, from which they are finally expelled without necessity of very much straining.

There are other features "Interol" possesses, but this one is perhaps the greatest, and if you are personally interested in this subject, we would be very glad to send you a pint bottle with our compliments, so that you may make personal observation without having to take out word for the merits of "Interol."

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Overcoming Hepatic Engorgement.

Active stimulation of the liver is often urgently needed in certain diseases—notably those of an auto-toxic nature, or characterized by faulty elimination—but not infrequently the efficiency of the remedy used is modified, or completely nullified, by the catharsis incidentally produced. In Chionia, a preparation of chionanthus virginica, the practitioner fortunately has an effective cholagogue that can be relied upon to increase the functional activity of the liver to a marked degree, without unduly stimulating the bowels.

Chionia is invaluable, therefore, for relieving hepatic engorgement, overcoming biliousness and promoting free elimination of the biliary products. In other words, the use of Chionia assures the restoration of hepatic efficiency, but unlike other cholagogues, without catharsis or purgation.

The Commonist Human Ill.

Probably the commonest single ill of modern mankind is what in lay parlance is termed dyspepsia, or in more scientific circles, gastric insufficiency, peptic deficiency, apepsia, and so on *ad libitum*. The actual condition, the result of abusing the stomach by improper food, irregular feeding, bad habits, etc., is a marked decline in the secretory activity of the gastric glands. The symptoms are legion but well summed up by the patient when he speaks of his suffering as "stomach trouble."

Recognition of the true state of affairs leaves the physician but one course to follow, activation of the glands of the stomach. Bitter tonics, dilute acids, and remedies galore have been used with varying degrees of success, but the remedy that has proven most uniformly satisfactory in restoring functional activity of the gastric glands is Seng. This is a trustworthy tonic to the stomach, a true secernent, that may be relied upon to restore the physiologic activity of the glands and thus overcome the distress and discomfort that make the gastric patient's life so miserable and burdensome. Have you some troublesome case of gastric insufficiency? You will be highly gratified at the result you can obtain with this useful remedy. Write for a sample to Sultan Drug Co., St. Louis, Mo.

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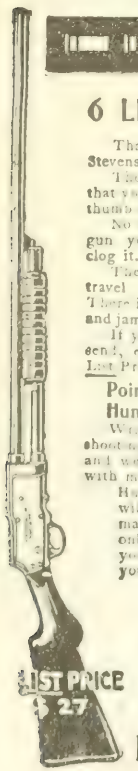

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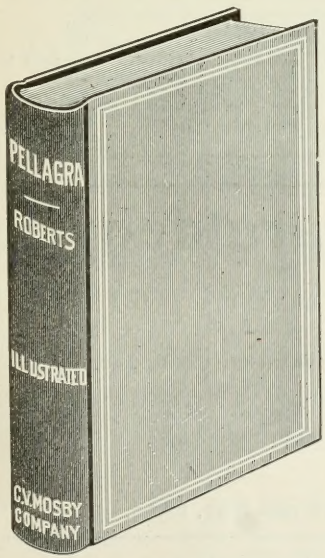

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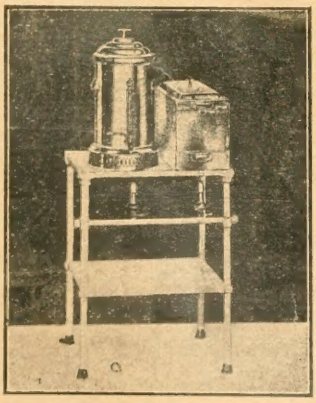

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